but if the patient is not already taking anti-Parkinsonian drugs levodopa is not a very good agent to use in these circumstances, as it takes a longer time, usually about three weeks, to show its therapeutic effect. Sacks *et al*[1] reported that 12 of 25 patients treated with levodopa for the first time developed "florid respiratory crises," while an additional eight patients developed respiratory and phonatory "tics."

The mortality in Parkinsonian patients with respiratory infection is much higher than in other groups of ill elderly patients. In the past this type of incident, which should be termed a "respiratory crisis," has not attracted sufficient attention from practising physicians. If geriatricians were more alert to the danger and to the need to give additional treatment for their patients' Parkinson's disease when respiratory infection occurs a large number of deaths in the elderly could be prevented, particularly in the winter.

B C KUNDU

St Francis's Hospital,
London SE22

[1] Sacks, O W, Kohl, W, and Messeloff, C, *Lancet*, 1970, **1**, 1006.

Necrotising enterocolitis

SIR,—Your leading article on necrotising enterocolitis of the newborn (21 January, p 132), although commendable in its discussion of epidemiology and possible aetiology, gives little useful guidance on the indications for surgery. Failure to improve on conservative management is a prime indication, but you make no mention of the commonest indications —peritonitis and signs of perforation with free gas seen on a plain radiograph. A review of 12 cases coming to surgery in one hospital in Bristol showed the indications to be peritonitis (6 cases), perforation (4 cases), and obstruction (2 cases) and in this series 75% recovered. In addition, in other published series I have studied[1-3] "persistent bleeding from the gut" has not been an indication for surgery in any case.

S M JONES

University Department of Surgery,
Bristol Royal Infirmary,
Bristol

[1] Stevenson, J K, *et al*, *American Journal of Surgery*, 1969, **118**, 260.
[2] Dudgeon, L D, *et al*, *Journal of Pediatric Surgery*, 1973, **8**, 607.
[3] Stein, H, Kalvin, I, and Faerber, E N, *Journal of Pediatric Surgery*, 1971, **10**, 943.

Treatment of hereditary angioneurotic oedema with methandienone

SIR,—The usual treatment of hereditary angioneurotic oedema in the past few years has been with epsilon-aminocaproic acid and possibly with fresh frozen plasma transfusions on rare occasions if a severe attack with laryngeal obstruction threatens. Androgens have also been used and Spaulding[1] showed that methyltestosterone had a beneficial action. Later less masculinising androgens, fluoxymesterone and oxymetholone,[2] and also danazol[3] have been shown to be effective.

We report here the excellent results of treating two patients with methandienone (Dianabol). They were non-related men aged 31 and 27 and had had attacks of angioneurotic oedema and abdominal pain every few weeks for many years. In both cases the C1 esterase inhibitor was absent or, in one case, was on one occasion only 10% of the mean normal adult value. Both patients had been helped by epsilon-aminocaproic acid but attacks still occurred every few weeks and plasma transfusions had been necessary at times.

Both patients have now been on methandienone 5 mg twice daily for 10 and 8 months, respectively, and during these periods have remained completely clear of attacks. In addition, in both cases the level of C1 esterase inhibitor has returned to normal values. No adverse effects have been noted.

E M SAIHAN
R P WARIN

Bristol

[1] Spaulding, W B, *Annals of Internal Medicine*, 1960, **53**, 739.
[2] Davis, P J, Davis, F B, and Charache, P, *Johns Hopkins Medical Journal*, 1974, **135**, 391.
[3] Gelfand, J A, *et al*, *New England Journal of Medicine*, 1976, **295**, 1444.

Adrenocortical suppression in workers manufacturing synthetic glucocorticoids

SIR,—I have read the paper by Dr R W Newton and others (14 January, p 73) three times but found no mention of the name of the offending synthetic glucocorticoid. Such reticence may be rather touching for the drug company concerned, but is surely scientifically unacceptable. With the missing name supplied their paper may well become of great interest, while without it it seems pointless and even (for those who have guessed wrongly) misleading.

DAVID C ANDERSON

Hope Hospital,
Salford, Lancs

**The authors preferred not to name the drug on the grounds that the manufacturers had been so helpful in arranging the study.—ED, *BMJ*.

Otosclerosis and the operating microscope

SIR,—As a retired otologist I greatly appreciate the short leading articles in the *BMJ* which so often give some idea of what aspects of medical science are attracting attention at the present time. It distressed me, therefore, in the recent article on otosclerosis (14 January, p 63) to find some serious inaccuracy in historical fact. To some this may seem of small importance, but as these articles are well documented they may be accepted and quoted and error then become fact. I refer to the information regarding Julius Lempert which is not in accordance with fact.

Julius Lempert never used the operating microscope; instead he used Cameron magnifying spectacles. The article referred to[1] makes no mention of a microscope but refers on p 62 to the necessity for "powerful magnifying glasses" which are the Cameron glasses referred to above.

The credit for the introduction of the operating microscope must go to Sweden, where Professor Gunnar Holmgren pioneered the fenestration operation with great pertinacity and courage in face of failure. He stimulated workers in many countries, including Julius Lempert in America. Lempert's great contribution was the description of the one-stage operation, which was made possible by the introduction of chemotherapy. In conclusion I would add that I have seen Julius Lempert operate many times in New York and counted him as a close friend for whose surgical achievements I have great admiration.

There are other matters in this article with which one might well disagree, but these are matters of opinion. At least let us get the matters of fact correct.

I SIMSON HALL

The Library,
Royal College of Surgeons,
Edinburgh

[1] Lampert, J, *Archives of Otolaryngology*, 1938, **28**, 42.

Threadworms in homosexual males

SIR,—Threadworm infestation is common in childhood, when it is acquired by eating contaminated food or having contact with infected clothing or other fomites. In recent years infections have been described in homosexual males,[1] but the mode of transmission in such cases has not been clearly defined. The following is a report of a young homosexual male who apparently acquired the infection during oroanal sexual intercourse.

An 18-year-old mechanic attended a department of sexually transmitted diseases complaining that he had had perianal irritation, particularly at night, for two weeks and had noted "worms" on his stool on one occasion. Threadworms in the anal canal were noted on proctoscopy. Rectal cultures for *Neisseria gonorrhoeae* and for *Chlamydia trachomatis* were negative, as were serological tests for syphilis.

He had had one sexual relationship during the preceding nine months and on that occasion, two months before attending the clinic, had had oroanal and orogenital contact only. His contact, a 20-year-old clerk, attended the clinic several days later at the request of the patient. He was asymptomatic, but a Scotch tape swab from the perianal region[2] showed five eggs typical of those of *Enterobius vermicularis*. This young man had had several homosexual relationships, all casual, within the preceding six months, but none could be contacted to be examined.

Oroanal contact is a common practice among homosexual males, at least 70% of those attending this clinic having performed this at some time. While it is impossible to be absolutely certain that the patient described above acquired his infection in this way and not, for example, from contaminated fomites, the history of contact with an infected person followed by a prepatent period is strongly suggestive that this was the mode of transmission.

A MCMILLAN

Glasgow

[1] Markell, E K, and Voge, M, *Medical Parasitology*, 4th edn, p 357. Philadelphia, Saunders, 1976.
[2] Waugh, M A, *Transactions of the St John's Hospital Dermatological Society*, 1972, **58**, 224.

Central dopamine blockade in anorexia nervosa

SIR,—Dr M R Trimble (10 December, p 1541) reported a rapid weight gain in a female patient with anorexia nervosa treated by weekly injections of fluspirilene. The patient also "felt very much better" and "lost her